Cesarean Section (CSEC)

Definitions of Data Fields on Supplemental Data Collection Form

Date of operation: Date the operation was performed. This date must match the date of operation entered into the basic surgical patient denominator data entry screen. Enter date in *MM/DD/YY* format, i.e., *MM* is the number of the month, *DD* is the day, and *YY* is the year. For example, April 15, 1997 is entered as 04/15/97.

Patient ID #: Patient identifier assigned by the hospital and may consist of any combination of no more than 12 letters and/or numbers. This number must match the patient ID # entered into the basic surgical patient denominator data entry screen.

Discharge date: Date the patient was discharged from the hospital. Enter date in *MM/DD/YY* format, i.e., *MM* is the number of the month, *DD* is the day, and *YY* is the year. For example, April 15, 1997 is entered as 04/15/97.

Height: Height of patient at the time of the operative procedure. The height recorded during the admission history and physical exam is acceptable. Circle *ft* and *in* for height in feet and inches or *m* and *cm* for height in meters and centimeters. Report height in whole numbers, i.e., round down if $\leq 1/2$, round up if $>1/2$.

Weight: Weight of patient at the time of the operative procedure. The weight recorded during the admission history and physical exam is acceptable, unless there is significant change in weight by the date of operation. In that case, record the weight taken nearest the date of operation.

Circle *lbs* for weight in pounds or *kg* for weight in kilograms. Report weight in whole numbers, i.e., round down if $\leq 1/2$, round up if $>1/2$.

Patient had <u>any</u> prenatal care: If the patient had prenatal care at any time before the C-section, circle *Y* for yes; *N* for no; or *U* if there is no record of prenatal care.

If *Y* and the patient had *>=7* visits, circle *Y*. If the nurses' or physicians' notes indicate "poor" or "little" prenatal care, circle *Y* for any prenatal care, rather than *U*nknown, and *N* for number of visits >=7.

Patient was in active labor in the hospital's labor and delivery (L & D) area: If, while in the hospital's L & D area, the patient was having regular uterine contractions that were progressively dilating the cervix, circle *Y* for yes; otherwise, circle *N* for no.

If *Y*, enter the number of hours (hrs) of labor the patient had while in the L & D area. Do not include number of hours of labor that may have occurred before the patient was admitted to L & D. Report hours in whole numbers, i.e., round down to nearest hour if ≤30 minutes, round up to nearest hour if >30 minutes.

Patient had intact membranes on admission: If the fetal membranes were not ruptured when the patient was admitted to the hospital, circle *Y* for yes; otherwise, circle *N* for no.

If *N*, enter the amount of time (in hours) the fetal membranes had not been intact prior to admission to the hospital. If the time is >96 hours (4 days), enter 99.

If *Y* (membranes intact on admission), but they ruptured >30 minutes prior to the C-section, enter the number of hours (≥1) elapsed between rupture and operation. If the membranes did not rupture or ruptured ≤30 minutes prior to C-section, enter 0.

For both *Y* and *N*, report hours in whole numbers, i.e., round down to nearest hour if ≤30 minutes, round up to nearest hour if >30 minutes.

Estimated blood loss: Record the amount of blood lost in milliliters (*ml*) by the patient during the C-section as estimated by the obstetrician.

Parenteral antibiotic prophylaxis given within 2 hours before skin incision or immediately after cord clamping: If the first dose of a parenterally administered (IV or IM) antibiotic(s) is given within two hours before the skin is incised **or** immediately after the umbilical cord is clamped, circle *Y* for yes; otherwise circle *N* for no.

If *Y*, enter the code of the antibiotic *Agent*, the *Dose* in milligrams (*mg*), and circle the route of delivery (***IV*** if intravenously or ***IM*** if intramuscularly). List one or two agents, their dosages and routes. If the dosage exceeds the allotted space of four digits, enter 9999. The names and codes of the antibiotics are on the attached list.